

**KING COUNTY FIRE CHIEFS ASSOCIATION
SEATTLE–KING COUNTY**

MULTIPLE CASUALTY INCIDENT PLAN

June 11, 2001

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Seattle–King County Multiple Casualty Incident Plan June 2000

LETTER OF AUTHORITY

The original Regional MCI Plan was described in 1989 at the express direction of the King County Fire Chiefs Association. This early work was carried out as an activity of the KCFCA Operations Committee.

The current review and revision of this MCI Plan was directed by the KCFCA, to be completed in the year 2000. MSO Tom Gudmestad of King County Medic One carried out this work with the assistance of the individuals named in the “Acknowledgements.”

This MCI Plan and its component parts exist under the authority of the KCFCA, whose members maintain the exclusive rights of review and revision.

The Seattle-King County MCI Plan is incorporated as part of the King County Fire Resource Plan.

John R. Ryan, President
King County Fire Chiefs Association

_____(date)

INTRODUCTION & ACKNOWLEDGEMENTS

The first Seattle-King County Multiple Casualty Incident (MCI) Plan was described in 1989. The final, revised edition was published and distributed in May 1994. That first version resulted from the contributions of a number of individuals. In the intervening years, a number of changes have been made possible based on additional research, a number of MCI experiences, and post-incident analysis.

In April 1999, the King County Fire Chiefs Association directed that a work group be formed to review and revise the original MCI Plan. The following document is the result of that review and revision.

The individuals who participated in this work are:

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MSO Tom Gudmestad - King County Medic One
Assistant Chief Steve Hamilton - Kent Fire Department
Captain Marty LaFave - Bellevue Fire Department
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Lieutenant Rick Newbry - Seattle Fire Department
MSA Ed Plumlee - King County Medic One
Lieutenant Don Sharp - Seattle Fire Department

This document should be considered a “work-in-progress” that will benefit from regular review and, when pertinent, revision.

PURPOSE & GOALS

The Seattle-King County MCI Plan is designed to provide direction, continuity, and organization to the delivery of emergency patient care during a significant medical incident.

This plan is based on the principles of the Incident Management System (IMS) and is intended to serve as a flexible guide to achieve successful incident management. Individual jurisdictions may implement portions of this plan as needed to provide the best medical results under the prevailing circumstances. This plan will provide utility at both small and large incidents. Its component parts should be practiced whenever possible and appropriate.

In the management of the MCI, the following are recognized goals of the tactical-medical activity.

- 1) ***Safe, rapid, and adequate response to the incident***
- 2) ***Rapid containment of the scene to achieve greatest accountability***
- 3) ***Accurate and rapid size-up of the incident, including initiation of an “MCI Response” appropriate for the number and injuries of the patients***
- 4) ***Creation of an organizational structure for the most effective deployment of resources, personnel, and equipment***
- 5) ***Rapid triage, treatment, and transport of patients to appropriate regional hospitals based upon medical priority and available resources***

DEFINITION AND SPECIAL PROVISIONS

In providing daily emergency medical service, responders often lavish abundant resources on one patient. At a Multiple Casualty Incident (MCI), however, there may be a sustained period where the number and medical needs of many patients overwhelm the rescuers. This means that a different approach to managing MCIs from that of regular, daily operations must be used. Successful management of an MCI is related more to on-scene organization and communication rather than specific medical procedures.

Organization will:

- 1) ***achieve span-of-control by dividing up on-scene responsibilities.***
- 2) ***identify position commanders.***
- 3) ***manage inter-agency cooperation.***
- 4) ***maximize communications.***

The precise definition – and recognition – of an MCI is often difficult to explain. Their nature defies universal description. Limitations of the scene environment, lighting, weather, topography, mechanism, etc., often make it impossible for first-arriving rescuers to gauge the full extent of the incident. The evolving nature of some incidents delays the recognition of the full magnitude of the situation. ***The definition of an MCI must be simple and left up to the discretion of the Incident Commander.***

The working definition of an MCI: **“An incident in which the number of patients or the severity of their injuries prohibits immediate patient care provided to all.”**

This definition cannot be achieved strictly based on number of patients. For example, an incident with five Red-taped patients poses a number of different challenges than an incident with ten Yellow-taped patients. Both incidents, however, will have the common components of “Transport” and the impact of environmental conditions.

The principles necessary for the successful management of the smaller MCI are precisely the same required in larger scale incidents. Under this definition, the purpose may be defined in several ways, each having the same goal:

“To provide the greatest good for the greatest number.”

“To identify, treat, and transport the sickest patients first.”

“To efficiently move the patients to hospitals.”

Since transporting patients must receive high priority, all personnel must pay attention to scene setup, parking, and egress in order to expedite access to, and movement of, transport vehicles.

At MCIs, other tactical challenges often must be managed simultaneously with patient care: rescue, fire suppression, extrication, hazardous material mitigation, crime scene, etc. These tasks will quickly deplete available personnel and resources urgently needed for patient care and transport.

Based on the medical direction of Seattle-King County and contained within this MCI Plan, special provisions are directed to simplify the burden of patient care and transport at an MCI. These special provisions are:

- 1) *The components of this MCI Plan to direct the operations of an MCI.***
- 2) *An MCI dispatch matrix (“MCI Run Card”) for the rapid provision of resources based solely upon the number of patients, initiated by the communications center or the IC [See Appendix 1.0].***
- 3) *The use of Field Triage to determine which patients receive medical treatment and transport based upon medical priority, which patients may be “walked,” and which patients are not treated at all.***
- 4) *The tracking and accounting of each patient based solely on a discreet, assigned number. [Note: In some incidents; i.e., aircraft accidents, additional efforts may be required by federal regulations to identify each patient.]***
- 5) *Medical Standing Orders, Plan C, which permit regional ALS scope-of-practice and the cessation of treatment without medical consultation [See Appendix 2.0]***
- 6) *Limited emphasis on spinal immobilization during patient movement.***
- 7) *Limited paperwork required for individual patients. There is no requirement to complete an individual Medical Incident Report Form for each patient.***
- 8) *The use of “Hospital Control” for the distribution of MCI patients to area hospitals, coordinated through the Incident Transport Officer.***
- 9) *The use of BLS transport units to transport ALS patients.***

Because of the infrequent incidence of MCIs, every opportunity must be made to learn from the operations of those that occur. Documents and records must be made available and post-incident reviews and debriefings scheduled. The regional medical and hospital community may require explanation of the incident and the disposition of patients to area hospitals.

COMMUNICATIONS

Communications play an important role in every phase of MCI management. Their importance before, during, and after an MCI must be emphasized. Early attention to communications will help to maximize time, coordination, and the use of available resources.

Dispatch centers play a critical role in initiating the MCI response, supporting field operations, and coordinating overall communications. Comm center personnel locate and dispatch resources to the incident according to well-established incident criteria – specifically, the reported number of patients or at the direction of the Incident Commander [IC]. They assign units and tactical objectives to specific radio Talk Groups and process all radio transmissions.

In the past, several common communications problems plagued the management of large medical incidents.

- 1) The failure of dispatch personnel to fully appreciate their roles in the MCI setting***
- 2) The under-response to initial reports of the incident***

The solution is to train dispatchers to aggressively respond to information regarding the scope of the MCI.

Incident resources should be dispatched in a uniform, familiar manner based on predetermined criteria (i.e., number of patients), department operating procedures, and requests from the IC.

The predetermined MCI response matrix should be adopted and utilized as a standard component of the MCI Plan to provide the rapid dispatch of BLS, ALS, command, and transport units. [See Appendix 1.0]

Within the limits of the Seattle-King County MCI Plan, communications personnel are granted the authority and responsibility to automatically initiate the first level of MCI response (1-10 patients) based on information received from reporting parties.

Time and experience will provide the dispatch personnel with the knowledge to gauge the accuracy of reported information and determine when it is appropriate to automatically initiate an MCI response.

The following are lists of dispatcher responsibilities, grouped in chronological sequence, which will greatly assist field personnel in the successful management of large medical incidents.

During initial response:

- 1) The dispatcher will determine the precise nature of the incident, “mechanism,” severity of injuries, and number of patients (or the existence of “multiple patients”), and relay this to responding units. Provide immediate updates with any new, revised, or additional information. This may allow responding units to modify the response while still enroute.***

- 2) ***Under existing guidelines, dispatch personnel are authorized to automatically dispatch the first level of the MCI Response Matrix, the 1-10 patient MCI.***
- 3) ***Additionally, dispatchers are authorized to automatically dispatch up to three (3) medic units to an incident if they suspect the presence of three (3) or more Red-taped patients. [Dispatch personnel must be trained to recognize the pertinent patient triage criteria for Red-taped patients.]***
- 4) ***Dispatchers will place highest priority on responder safety, advising of potential safety issues: haz-mat, weapons, swift water, explosions, energized power lines, etc.***
- 5) ***In addition to dispatch and response talk groups, communications personnel must consider the need for allocating multiple operational talk groups: "Operations," "Medical," "Transport," etc. These critical functions cannot wait for an opportunity to transmit needs and directions.***
- 6) ***Anticipate operational needs not provided for in the MCI response matrix: air-medical transport, haz-mat and rescue resources, police, public utilities, public transit, etc., and special considerations such as contacting the FAA to close the overhead air space.***

After arrival of first responding units:

- 1) ***Clearly and fully repeat reports from first arriving units including location, mechanism, number of patients, numbers of triage colors, name of command, and directions.***
- 2) ***If the initial report sounds like an MCI, ask the IC for clarification: "Are you declaring an MCI?" "Are you requesting an MCI response?" "Do you need additional resources?" When you hear the letters "MCI" transmitted, provide an MCI response. [Remember, "MCI" means, "We need help!"]***
- 3) ***Based on the reported number of Red-taped patients, dispatchers may automatically dispatch up to three ALS units total. Additional resources may be "offered" to the IC or Medical Group Supervisor [MGS] as the patient count or triage colors (Red-taped patients) increase.***
- 4) ***The communications center may be requested by the IC, the MGS, or the Transport Officer to notify "Hospital Control" to coordinate and direct patient transport destinations. [Harborview Medical Center is the **primary** "Hospital Control" facility at 206-731-3074; Overlake Medical Center is the secondary facility at 425-462-5100.]***

As soon as an MCI is declared, "Hospital Control" should be notified by the following process.

Telephone Seattle Fire Department Alarm Center: **206-386-1498**. Ask them to page:

Charge Nurse at HMC [May be phoned directly at **206-731-4025**]
Portable 55
SFD MSO

The information provided will be, **"An MCI has been declared. Report to the HMC radio room and establish Hospital Control."**

*A subsequent telephone call will be made directly into the HMC Emergency Room, **206-731-3074**, to confirm this notification. [See Appendix 3.0 for alternate notification, pager, and telephone numbers.]*

Additional dispatch responsibilities include:

- 5) *Utilize the King County Fire Resource Plan to obtain Strike Teams, Task Forces, and other mutual aid responses.*
- 6) *Provide regular updates on elapsed time: "Command, you are 30 minutes into this incident." **The regular, calm emphasis on time passage is critical.***
- 7) *At the twenty (20) patient level, or higher, the King County Emergency Operations Center representative will be notified: **206-296-3830**.*
- 8) ***These incidents are labor-intensive, and any request or information lost may have a significant impact on field operations. Dispatchers must have assistance. One person cannot, and should not have to, do it all.***

In order to support intensive, protracted communications activities, the automatic recall of staff or off-duty dispatch personnel may be required. A variety of MCI scenarios may overwhelm the existing communications staff and cause the dispatch center's critical support capacity to collapse.

Communications centers should have automatic and clearly defined procedures for the recall of additional staffing both to provide critical assistance during the incident and relieve personnel after the incident.

- 9) *Specialized Resources: Dispatchers must be familiar with the process for obtaining specialized resources requested by the IC. In addition to standard resources of BLS, ALS, command, and transport vehicles, the incident may require special MCI units, rescue equipment, pumps, cranes, saws, lights, shelter, food, and water. Responders and communications personnel must work together to make sure that any requests for resources will be met swiftly and successfully. **Fire departments must provide clear direction on existing plans and arrangements for rapidly obtaining special equipment.***

After the incident:

- 1) *Assist "field units" in the compilation of incident records.*
- 2) *Participate in post-incident debriefings [See Appendix 4.0].*
- 3) *Consider any necessary revisions to plans and procedures; recommend plan changes based on experience.*

MCI 2000: THE FIRST TEN MINUTES

Incident Command & Triage

Incident Command

The first ten minutes of any MCI will consume the initial dispatch, response, and immediate arrival of fire department EMS units. These are moments filled with confusion, uncertainty, and

fear, with personnel working under the compression factor of enormous stress. Stress erodes the ability for creative thinking, situational awareness, and problem-solving skills, yet it is under these conditions that **the actions of the very first personnel on location will determine the outcome of the entire incident.**

MCI plans and preparations should be focused on “saving time when time is critical.”

TIME + RESOURCES = Lives Saved!

The swift, accurate request for response and application of resources will have a direct impact on patient care and survival. [Remember: When under stress, It is easier to modify an existing, practiced plan than to create something original!]

Responding units should listen carefully and make note of the information provided during the initial alert by the dispatchers. These details, or those provided as an update, may permit a change in assignments, approach, or other safety considerations while the response is in progress. Safety of the responders, bystanders, and patients remains the highest priority of any incident. Dispatch may provide critical information to guarantee maximum scene and operational safety.

Parking of the first-arriving units should be appropriately managed to enhance scene safety and provide adequate access to equipment and lighting but should NOT inhibit the movement of transport units. Opportunities exist daily to practice the best method of parking a fire engine, aid car, medic unit, command vehicle, and ambulances to achieve the goals outlined above.

The first-arriving fire department unit should establish command according to the principles of the Incident Command/Incident Management System. The officer of this unit will assume the role of Incident Commander [IC] until relieved.

Establish an incident command structure to address span-of-control and to manage the different tactical “missions.” For example:

The IC must consider all tactical objectives: rescue, suppression, extrication, medical, civilian evacuation, containment, etc. While the emphasis at an MCI is on medical activities, these “other” objectives will rapidly drain personnel away from the Medical Group.

Consider those factors which may influence tactical objectives:

- Crime scene?
- Hazardous Materials?
- Weapons of Mass Destruction (WMD)?

Under these situations, a “Unified Command” may include representatives from Fire, EMS, law enforcement, utilities, public health, public government, EOCs, transportation, and environmental agencies.

Incident command responsibilities include:

- 1) **Radio report identifying unit and location of incident**
- 2) **Establish command, providing:**
 - Name and location of command**
 - Rapid scene assessment**
 - Brief description of incident, identifying mechanism, apparent energy involved, approximate number of patients**
 - Safety considerations, etc.**

- 3) ***Request for MCI response based on matrix or for additional units***
- 4) ***Directions for responding units, including approach, assignments, parking and staging, medical areas, ambulance staging, etc.***
- 5) ***Request for specialized equipment needs***
- 6) ***Separate Talk Groups as needed***
- 7) ***Follow-up report(s) to confirm the number of patients and their specific triage colors***
[See list of IC checklist, Appendix 5.0]

The burden upon the IC to provide almost constant communications may create an immediate need for a “Communications Aide” to assist with radio, telephone, and pager traffic.
[Remember the principles of “Span-of-Control!”]

Remember that multiple sites of the same function; i.e., two or more Treatment Areas, Transport Points, etc. will require distinct, identifying names. Streets, business names, or geographic points provide effective identifiers; i.e., “Broadway Command,” “Nordstrom Treatment,” or “West Transport.”

Triage

Available resources for patient treatment and transport should be allocated according to a system based on patients’ medical priority. Since all patients cannot be treated immediately in an MCI, patient care must focus on those in the greatest need. This system is called Triage.

Triage will be initiated by the driver, the first-arriving fire/EMS unit, or at the direction of the IC.

The goal of triage personnel is to:

- 1) expedite the medical goal of patient movement to area hospitals by rapidly locating every patient.
- 2) obtain an initial count for the IC.
- 3) request and direct additional triage resources.
- 4) direct the sorting and moving of patients based on their medical priority as indicated by the color of the tape on each patient’s wrist.
- 5) begin to number the patients at a Funnel Point, or as directed.

Triage Colors:

Red → “Urgent” or “Immediate,” imminent life danger. Highest priority

Yellow → “Delayed”; injured but can wait for care and transport

Green → Walking wounded; minor injuries. Direct these patients to extricate themselves from the incident and move to a place of safety. Depending upon numbers, they may be transported separately to a single hospital in a bus. *(These patients are “mobile” by definition and may defy all attempts to contain them. As such, they will provide a separate accountability and logistics challenge.)*

Black → “Expected” (to die); or “DOA”

White → Haz-mat or chemical-exposed patients who have been decontaminated

These colors should be clearly indicated by tying colored, plastic surveyor’s tape around the patient’s wrist. This placement will ensure that the tape is not removed during physical exams or treatment and will still be in place during transport.

The driver of the first-arriving fire unit ensures safe, appropriate parking for this vehicle and assumes the role of Triage Officer, working at the direction of the IC.

The Triage Officer’s responsibilities include: [checklist, Appendix 6.0]

- 1) *Obtain initial, approximate patient count for IC. This may be delivered by portable radio or by face-to-face communication as dictated by circumstances.*
- 2) *Initiate Field Triage by quickly assessing each patient as follows: Level of Consciousness, Airway, Breathing, and Circulation: A, B, C [See Appendix 6.1].*
- 3) ***Notify the IC of the presence of a single Red-taped patient, or the total number of Red-taped patients.***
- 4) *Request additional resources and equipment to accomplish triage of all patients in the shortest possible time.*

REMEMBER: Triage personnel are responsible for “sorting” all the patients into the correct category of medical urgency. THEY ARE NOT TO PROVIDE MEDICAL CARE. However, triage personnel may quickly attempt two techniques:

- a) Open the patient’s airway (to assess respiratory effort)
- b) Control life-threatening bleeding

In both of these instances, the attempts must be swift. If successful, the patient, another patient, or a bystander must be utilized to continue the care so that the triage individual may move on.

- 5) ***Determine that all triage personnel are working quickly, according to triage guidelines and that the patients are all “flagged” at the wrist with colored Triage Tape. Triage personnel must report with lights, triage belts, and backboards, prepared to work as part of the Triage Team.***
- 6) *Advise the IC or Medical Group Supervisor [MGS] as patient and triage color totals change.*
- 7) ***Guarantee that each patient is provided with an individual number, in sequential order, written in ink on the patient’s forehead, cheek, chest, upper arm, or hand. [This number may be applied at the incident, at a formal Funnel Point, or in the Treatment Area. If this has not been accomplished, the patients may be numbered at the time a hospital destination is obtained.] Triage personnel must ensure that each patient’s number is recorded, along with the triage color, to provide accurate consecutive numbering. These numbers may be tracked on a form, status board, gloved hand, piece of tape, etc. WRITE THEM DOWN! [See Appendix 7.0]***
- 8) *Tie a “Treatment Tag” to the colored triage tape. This will aid in documentation and accountability.*

9) *Direct triage personnel and litter-bearers to ensure the Red-taped patients are evacuated first and that Triage continues until only the Black-taped patients remain. [The dead are to be moved only at the direction of the IC or Medical Examiner.]*

10) Perform re-Triage whenever possible to determine patients' changing status.

11) *Downsize and redirect triage personnel to assist in other areas of the MCI as circumstances permit; i.e., to assist in Treatment or Transport Areas.*

12) *Ensure that accurate records are kept, collected, and verified with those of the Medical Group.*

[Note: The goal of Triage is to “move the worst, first!” but often the most seriously injured – the Red-taped patients – are the last to be moved. Gaining access to the patient may be difficult, and the Yellow-taped and Green-taped patients will “self extricate” to the medical area. Initiate the transport of any available patients while still giving priority to the accessible Red-taped patients.]

Other “early” incident command considerations include:

Parking: Emphasis placed on the parking of all apparatus at the incident. Remember that four types of vehicles respond quickly to the scene:

- Police
- Fire Department BLS units
- Paramedic ALS units
- Transport BLS units

The function of each unit will determine where it is best parked. The function of these resources may be defined as: “Stay for whole incident” (BLS); “Stay but may transport” (ALS); or “Transport only” (Ambulance). The operation will function most effectively if a sound parking plan is determined early and enforced. ***If someone parks in the wrong place, MAKE THEM MOVE!*** Vehicles may be shut off to reduce noise and exhaust. It is important that keys be left in unstaffed vehicles in the event they must be moved.

The IC and Triage Officer must determine early in the incident where the most effective Transport Point is to be located. The parking of all apparatus and the location and method of providing treatment should support the movement of transport vehicles.

Additional first-arriving personnel will work at the direction of the IC to support incident or triage activities.

Eventually, the Triage Officer and Triage Team personnel will become part of the Medical Group (and will report to the Medical Group Supervisor) once established.

Communications: On-scene communications will be one of the first, critical concepts to fail. Ambient background noise, apparatus engines, sirens, and confusion about radio talk groups all inhibit effective communications. Runners and face-to-face communications may be required to transmit orders and information. Tactical groups; i.e., “Operations,” “Medical,” etc., may be moved to their own separate Talk Groups and named accordingly. This requires multiple radios at the Command Post, each monitoring the separate Talk Groups.

REMEMBER “SPAN OF CONTROL:” Individual command positions within the MCI structure must be provided with aides to work in the following support capacities.

Communications Aide (one for each major Talk Group)
Runners (to provide face-to-face communications)
Scribes (for recording important data)

Other resources available to the Incident Commander may include:

Communications	Hospitals & Red Cross
Medical Examiner	Military
Public Health	Aero-medical
Coast Guard	Emergency Operations Centers
Red Cross	Law Enforcement (local, state, federal)

OPERATIONS: The Medical Group

Triage, Treatment, and Transport (and Morgue)

Depending upon the size of the incident and/or the number of patients, the Incident Commander may:

- 1) retain command of all phases of the incident, including the medical operations,**
or
- 2) establish an “Operations Section” to include specific tactical activities, including medical operations,**
or
- 3) create a Medical Group to work directly under the Incident Commander or an appointed Operations Commander.**

Personnel assigned to the medical activities must remain flexible and adaptable to the command framework established by the Incident Commander.

Positions within the Medical Group are identified as:

- I. MEDICAL GROUP SUPERVISOR**
- II. TRIAGE**
- III. TREATMENT**
- IV. TRANSPORT**
- V. MORGUE**

The most experienced medical personnel available should fill the positions of “Medical Group Supervisor,” “Triage,” “Treatment,” and “Transport.” [The “Morgue” may be staffed by a Firefighter/EMT until the arrival of Medical Examiner personnel.] They will report to the Medical Group Supervisor for status reporting and resource request purposes. (Any exceptions to the reporting structure will be delineated within each position’s responsibilities.)

I. MEDICAL GROUP SUPERVISOR

The senior medical person present should assume the position of Medical Group Supervisor (MGS). That individual should be identified on the Operations Talk Group as “Medical,” identified with a “Medical Group” vest, and be prepared to direct and coordinate all activities within the Medical Group. [see Appendix 8.0]

The MGS is responsible for managing all medical activities and communications to and from Triage, Treatment, Transport, and Morgue Teams, including all status reports and requests for resources. ***The MGS provides the “link” between the IC/Operations and the medical teams.***

Because critical medical communications must have priority, the Medical Group Supervisor should request a separate Talk Group – “Medical” – for the Medical Group. It will be necessary for the MGS to monitor the “Operational” Talk Group and the “Medical” Talk Group to communicate with the Incident Commander/Operations Section as well as all positions within the Medical Group respectively. Communications aides and runners should be assigned for duty with the MGS.

The key to success within the Medical Group is anticipating the need to promptly reassign personnel from one medical activity to another. Thus, as the number of patients moves from incident triage area, through the Funnel Point, to the treatment area, and then to the transport areas, personnel must be reassigned to meet the needs of each activity.

Medical Group operations must focus on the need to move patients from the incident site to regional hospitals. For this reason, the siting of the treatment areas and the corresponding Transport Point must take place with the goal of rapid and efficient patient movement. ***Facilitating the transport of patients remains a priority of the MGS.***

Remember that bystanders and citizens (“Good Samaritans”), as well as Green-taped patients, may represent an available source of personnel in the first ten minutes of an MCI when need is greatest and resources are scarce. Civilians utilized in this “Good Samaritans” capacity must be eventually assembled, identified, and documented for the purposes of incident follow-up and possible exposure. [see Appendix 9.0] At a haz-mat incident, they may require decontamination.

II. TRIAGE TEAM

In the first ten minutes of an incident, triage personnel report to the IC or designee. Once the Medical Group has been established, the Triage Team Leader and Triage Team members work under the direction of the MGS.

Triage Team responsibilities are:

- 1) *Locate all the patients.*
- 2) *Provide an initial, rough patient count to the IC (update as necessary).*
- 3) ***Request adequate resources from the IC for the rapid, precise triaging of all patients.***
- 4) *Separate all Green-taped patients by commanding them: “Everyone who can move, come and stand over here!” [When available, a treatment team member must monitor and re-evaluate the Green-taped patients.]*

- 5) *Initiate rapid triage of all patients using the guidelines of Mechanism, Airway, Breathing, and Circulation. Rapidly assess the patient as "Sick" vs. "Not Sick."*
- 6) *If dangers or hazards to triage personnel exist within the incident site, consider establishing a "Triage Area" free from danger for containing patients for Triage.*
- 7) *Report the presence of the first Red-taped patient to the IC.*
- 8) *Direct additional triage personnel as they arrive on scene.*
- 9) *Triage categories will be indicated by the application of appropriate colored, plastic triage tape to the patient's wrist. [Note: in haz-mat exposure incidents, White tape will be used to identify patients who have been decontaminated.]*
- 10) *Initiate harvesting of priority patients (Red-taped, then Yellow-taped) as staffing and circumstances permit.*
- 11) *Ensure that all patients, including the Green-taped patients, are numbered (see "Numbering Options" listed below).*
- 12) *Record and track the total number of patients as well as the numbers within each Triage category: Red, Yellow, Green, Black. Keep the IC briefed on the numbers and changing totals of each category.*
- 13) *Continue to direct Triage Team and litter-bearer crews until all patients are either gone or triaged Black. (Do not move dead bodies.)*
- 14) *Downgrade Triage Team members and reassign them to other operations within the Medical Group to expedite patient movement and transport.*
- 15) *Maintain accurate records, documenting number of patients and their Triage colors.*

Patient Numbering Options:

Patient numbering provides a critical means of identification and tracking of patients within an MCI. This responsibility also presents a number of challenges that must be anticipated and met. Use a marker pen to write consecutive, discreet numbers on each patient in the following order as opportunity allows.

- 1) forehead
- 2) cheek
- 3) chest
- 4) shoulder
- 5) upper arm
- 6) back of the hand

Multiple numbers may be necessary to ensure that one number remains visible after patient treatment has concluded. On incidents with lightly-injured or non-injured patients, numbering is easily achieved by numbering the back of the hand. In order to avoid "dropping" or "repeating" a number, personnel performing this task **must write it down**. An aide for this purpose is the most secure way to guarantee correct patient numbering. [see Appendix 7.0]

While numbering the patient remains the priority, flexibility exists to carry out this requirement. Depending on circumstances, patients may be numbered:

- 1) within the initial incident site.

- 2) at a formal "Funnel Point" if the incident size and location requires it.
- 3) within a separate "Triage Area" if hazards deem this necessary.
- 4) within the Treatment Area if patients have been moved there.
- 5) at the Transport Point as hospital determinations are made.
 - a) inside transport vehicles before departure for hospitals
 - b) "Hospital Control" is able to coordinate patient numbering as patients are loaded and transport destinations determined

*If numbers are unavoidably "dropped" or lost during the numbering process, one solution may be to "jump" ahead to another "hundred-block"; i.e., changing from patient "29" to patient "101." This option, however, clearly contributes to confusion regarding total patient count. This necessity can be avoided if personnel providing the numbers **WRITE DOWN THE NUMBERS ASSIGNED**. [see Appendix 7.0]*

Green-taped patients are normally separated quickly from the other remaining patients. Because of this, it is difficult to number them consecutively with the other patients. It may be necessary to assign them "G-#" (for "Green-#) or assign them an available block of numbers at the end of the incident. This may be achieved before, during, or after moving Green-taped patients to buses or other transport vehicles.

Every Black-taped patient must be numbered and added to the total patient count at the conclusion of the incident.

Geographically separate but related incidents will require discreet numbering identifiers to link the patient to a specific site and its treatment and transport areas. These identifiers may be road or street names, compass directions, formal names, or command identifiers. There is no clear solution to every possible dilemma.

Remember that in haz-mat or WMD incidents, the patients MUST BE DECONTAMINATED before being triaged or treated by medical personnel. The patient's "deconned" status is confirmed by White triage tape tied to the wrist. It may help in the process of decontaminating patients to have zip-lock, plastic bags available to secure each patient's valuables. These can be marked with the patient's number and secured, or sent with each patient as circumstances permit.

III. TREATMENT

The decision to establish a Treatment Area, its scope, sophistication, and location will be based upon significant incident factors:

- The number of patients*
- The availability of vehicles or other shelter*
- The ability of transport vehicles to access the incident*
- Weather and other environmental factors*

Under normal, daily conditions and especially in cold, wet weather, patients are usually placed directly into transport vehicles for examination and treatment. Transport is obviously expedited by this practice.

When should medical personnel switch from placing patients directly into transport vehicles to creating physical treatment areas, outside, on tarps on the ground? When

the number of patients exceeds available transport vehicles or shelter, when treatment personnel are unavailable, or when transport vehicles cannot access the incident. No advantage for patient care is obtained by creating treatment areas in the dark or in rain, snow, or cold weather.

The timely request for transport vehicles, appropriate staging, and parking at the Transport Point will provide suitable configurations for the benefit of both patient treatment and transport.

The IC or MGS must give early consideration to the location of the Treatment Area and its relationship to the closest, functional Transport Point. Directions for the parking and staging of apparatus will ensure that patients are moved to a location that will facilitate their eventual transport.

When the number of patients and availability of transport vehicles permit and environmental conditions dictate, patients should be placed inside transport vehicles. This will allow maximum use of lights, medical supplies, equipment, and shelter, and will ultimately expedite the transportation of the patients to hospitals. In order to exercise maximum control and coordination of these patients, the transport vehicles must be grouped and parked to carry this out; i.e., side-by-side or end-to-end. [For a checklist of treatment responsibilities, see Appendix 10.0.]

In the most common Treatment scenario, as well as the most favorable one for rapid transportation, the patients are loaded directly into properly parked transport vehicles. This configuration will still permit adequate access by medical treatment personnel as well as control by the Transportation Team Leader.

If transport vehicles are not available or cannot access the incident site, treatment areas for the Red-taped and Yellow-taped patients will have to be established. Priority; i.e., proximity to the Loading Point, must be given to the Red-taped patients. Patients should be placed in these treatment areas, with their heads aligned, pointing in the direction of transport. This will expedite both treatment as well as movement.

Treatment Tags

Patient information, triage color, number, vital signs, etc. should be noted on the Treatment Tag. If tags have not been tied onto the triage tape previously, they should be applied in the Treatment Areas. This tag will be completed and the bottom portion retained by transport personnel before the patient leaves the scene.

The minimum information required on both the top and bottom portions of the tag is:

Patient number
Triage color
Hospital destination

[see Appendix 11.0]

Patient medical care should be limited to those procedures which are truly life saving. Every effort should be made to not impede the smooth and orderly transportation of patients to regional hospitals.

IV. **TRANSPORT**

The most important, and often the most difficult, function of the Medical Group is the transportation of the patients to available hospitals. Communications, environmental conditions, the distance from the incident site to the Transport Point, lack of resources, etc. all negatively impact the medical goal of the MCI; i.e., movement of patients to receiving hospitals.

Goals of the Transport Area are:

- 1) ***Keep patients moving to the hospitals. (Avoid patients piling up at the Transport Point!)***
- 2) ***Establish and maintain communications with Hospital Control and the MGS.***
- 3) ***Maintain records of patient numbers, triage colors, and destinations. It is also useful to note transporting vehicle number and time departed.***

The Transport Loading Point must be located close to the Treatment Area to facilitate the loading of patients directly into vehicles.

Transport Vehicles:

Backing of vehicles should be avoided whenever possible. If they must be backed into position, it should be accomplished on their arrival, not after patients have been loaded.

When resources permit, transport vehicles should be parked to permit the immediate loading of patients as they are carried from the incident. **If vehicles are available at the scene and conveniently parked, LOAD THEM IMMEDIATELY!** Patient care can be provided and hospital destinations obtained after the patients are loaded. Transport vehicles must not leave, however, without clearance from the Transport Officer.

At the Transport Point, vehicle crews may be required to help load their patient(s). A Loading Officer may help facilitate the activities at the Transport Point.

In order to maximize control over both patients and transport vehicles, the vehicles must be arranged to permit greatest control over the patients; ideally, all visible from a single vantage point. Vehicles should be parked "slanted" or at an angle, to allow any one of them to depart independently of the remainder.

Transport vehicles may be "staged" until needed at the Transport Point, although, if possible, vehicles should be moved up to this position for immediate loading. While in Staging, transport crews should remain in their vehicle. An ambulance company supervisor may prove useful as a contact at Ambulance Staging.

Keys must be left in the ignition of transport vehicles any time they are not staffed. Aero-medical (helicopter) transport may be considered, but its value must be weighed against any negative impact on scene security, ground personnel, and time.

Hospital availability and patient destinations:

Patient destinations are coordinated by "Hospital Control" in order to obtain maximum benefit from the available resources. It is important to notify "Hospital Control" as quickly as possible once an MCI has been declared. Regional hospital bed status is provided by an Internet web site that is updated twice daily by participating hospitals.

Communication with Hospital Control should be established by the senior medical provider anytime the number of patients exceeds the normal process for patient distribution.

The Transport Officer is responsible for establishing contact with “Hospital Control” via cell phone or radio. “Hospital Control” is provided by:

- 1) Harborview Medical Center (primary): 206-731-3074
State the mechanism and number of patients.
On the 800 MHz radio, use the “Harborview” or “Trauma” Talk Group [see Appendix 12.0].
- 2) Overlake Medical Center (backup): 425-462-5100 or “Overlake” on the 800 MHz radio

The Seattle Fire Department Alarm Center may also be utilized to contact “Hospital Control.” Call **206-386-1498** and request them to “**Activate the MCI Hospital Control Plan**” and page in the following order:

- 1) The HMC “Charge Nurse” [May also be phoned directly at: 206-731-4025]
- 2) Portable “55”
- 3) The SFD MSO (Portable “33” or “44”)

The Communications Center may also activate “Hospital Control” for incident personnel at the request of the IC or MGS. Communications personnel must use the guideline outlined above.

If communications with “Hospital Control” has not/cannot be established:

- 1) The first ten (10) patients may be sent directly to HMC with little or no prior contact.
- 2) Consider sending 1-2 Red-taped patients to each of the other regional trauma hospitals. Whenever possible, trauma patients will be sent to trauma designated hospitals. In order to avoid overloading local hospitals, coordinate patient destinations with Hospital Control.
- 3) It must be assumed that the closest hospital to the incident will be inundated with patients who “self-direct.” For this reason, until its status is determined otherwise, no patients from the incident will be sent to this hospital. Eventually it must be accepted that even hospitals reporting themselves as “full/closed” or “on divert” may receive patients anyway.

Large numbers of Green-taped patients may be moved by bus. Bus or other transit resources should be added to MCI Response Plans.

Consider the need to utilize specialty hospitals for specific patients:

<i>Level I Trauma</i>	<i>Pediatrics</i>
<i>OB-Gyn</i>	<i>Burns</i>
<i>Smoke/Carbon-Monoxide Poisoning</i>	<i>Neuro Emergencies</i>

*In order to expedite patient transport and to maximize available vehicles, **MULTIPLE PATIENTS MAY NEED TO BE LOADED INTO A SINGLE VEHICLE.** Whenever possible, avoid grouping unstable patients.*

Once the hospital destination has been determined and recorded, that vehicle should LEAVE!

*While transporting to the hospital, the transport vehicles should **STAY OFF THE RADIO.***

The Transportation Officer is responsible for recording information relative to the transport of each patient. This information is required on both the "Treatment Tag" (top and bottom) and on a Transport status board:

Patient #

Triage color

Hospital destination

Transport vehicle

Time departed

The Transport Officer should retain the bottom, tear-away portion of the Treatment Tag with this information to assist in final accountability.

Although not required at this time, any additional patient identification, especially with children, is desirable and might be possible depending upon the circumstances:

Age

Sex

Initials

"Child"

A few extra details may mean the difference in quickly reuniting family members after the incident. [Note: see checklist of duties and responsibilities in Appendix 13.0.]

V. MORGUE

The duties of the Morgue Team Leader are:

- 1) *Identify the location of each Black-taped patient*
- 2) *Ensure that each Black-taped patient is assigned a number to be added to the final patient count*
- 3) *Provide security for human remains until this responsibility can be turned over to the Medical Examiner's personnel*

[Note: see checklist of duties and responsibilities in Appendix 14.0]

Black-taped patients are not to be moved by triage personnel. Patients who are re-triaged to Black at other locations within the Medical Group, should be covered, secured, and eventually moved to an established "Morgue" site.

[Note: Personnel who have been involved in Triage and other medical duties should not be utilized for the movement of Black-taped patients at any time. Fresh personnel, if available, should be brought forward for this purpose at the conclusion of all other medical activities.]

MCI Appendix 1.0

**MCI Dispatch Matrix / “MCI Run Card”
(Sample a)**

Multiple Casualty Incident
“Run Card”

Patients	FIRE UNITS (BLS)	MEDIC (ALS)	MSO	MSA	TRANSPORT VEHICLES
1-10	4 Total (Aid/Engines/Ladder)	No	1	0	5 Ambulances
11-19	8 Total (Aid/Engines/Ladder)	No	2	1	10 Ambulances
20-29	12 Fire Units and BLS Strike Team *Zone MSU	Yes	2	1	15 Ambulances
30-39	16 Fire Units and BLS Strike Team *Zone MSU	Yes	2	1	20 Ambulances 1 Bus
40-49	16 Fire Units and BLS Strike Team and Task Force *Zone MSU	Yes	3	1	25 Ambulances 2 Buses
50+	16 Fire Units and 2 BLS Strike Teams and Task Force *2 Zone MSU	Yes	4	1	25 Ambulances 3 Buses
100+	16 Fire Units and 3 BLS Strike Teams and 3 Task Force3 *3 Zone MSU	Yes	5	1 King 1 Seattle	25 Ambulances 4 Buses

* = Zone MSU (MCI supply unit, IE “MCI 75”)

Note:

Dispatch may automatically initiate first level (1-10 patients)

MCI response plus add a third medic unit

MCI Appendix 1.0

**MCI Dispatch Matrix / “MCI Run Card”
(Sample b)**

Patient Count*	Fire Units▲	MCI75+	Medic Units	MSO	MSA	Transport Vehicles
1-10 (Level 1) MCI1F	4 Fire Units (Aid/Engine/Ladder)	No	2	1	0	5 Ambulances
11-19 (Level 2) MCI2F	8 Fire Units (Aid/Engine/Ladder)	No	3	2	1	10 Ambulances
20-29 (Level 3) MCI3F	12 Fire Units and 1 Task Force	Yes	4	2	1	15 Ambulances
30-39 (Level 4) MCI4F	16 Fire Units and 1 Task Force	Yes	5	2	1	20 Ambulances 1 Bus
40-49 (Level 4) MCI4F	16 Fire Units and 1 Task Force and 1 Engine Strike Team	Yes	5 Medic Units and 1 ALS Strike Team	3	1	25 Ambulances 2 Buses
50-99 (Level 4) MCI4F	16 Fire Units and 1 Task Force and 2 Engine Strike Team	Yes	5 Medic Units and 1 ALS Strike Teams	4	1	25 Ambulances 3 Buses
100+ (Level 4) MCI4F	16 Fire Units and 3 Task Force and 3 Engine Strike Team	Yes	5 Medic Units and 2 ALS Strike Teams	5	1 King 1 Seattle	25 Ambulances 4 Buses

* To upgrade incident to an MCI use the balance command (IE BAL E71 T/MCI1F)

▲ If you do not have enough units available to meet the response requirements add an addition Strike Team or Task Force.

+ MCI75 will not appear on the run card. Add them by using the dispatch command (IE DMCI75). MCI75 is stationed at Kent's Sta. 75. It is to be added to MCI response of 20 patients or more.

MCI Appendix 2.0

Plan C

“MCI Standing Medical Orders”

I. The MCI Standing Medical Orders are to be adopted under the following conditions:

- A. A multiple casualty incident has occurred and:
 - 1.) Medical direction is available but paramedics are unable to obtain medical direction without jeopardizing patient care.
 - 2.) Medical direction is NOT available, regardless of the number of casualties/patients. (No communication is possible via phone or radio and no supervising physician is available.)
- B. Authorization for paramedics employed by Seattle-King County ALS providers to act pursuant to these MCI Standing Medical Orders in effect while on assigned duty or while off duty if called to respond to an MCI.

II. MCI Standing Medical Orders:

- A. Paramedics will treat, whenever possible, patients in order of medical priority, i.e. Red patients first, Yellow patients only as time allows and Green and Black patients only after assuring that all Red and Yellow patients have been stabilized.
- B. Standard of care shall apply when operating under a declared MCI. The Hospital Control facility shall serve as Medical Control for the incident.
- C. No permission is required for “cease efforts.”
- D. If Hospital Control is not activated, and if communication is possible, the Transportation Team Leader should notify the receiving hospital(s) of patient status, providing patient number, Triage color, injuries, treatment and disposition prior to patient transport.

MCI Appendix 3.0

Telephone Numbers

ALS Program numbers and MSA/MSOs: see reverse

Dispatch centers:

Seattle Fire Department	206-386-1498
Valley Communications	253-854-2005
Eastside Communications	425-885-3131

Hospital Control

Primary

Harborview Medical Center	206-731-3074
HMC Charge Nurse	206-731-4025
(or use "Harborview" or "Trauma" on 800mhz radio)	

Back-up

Overlake Medical Center	425-462-5100
(or use "Overlake" on 800mhz radio)	

Miscellaneous:

Airlift Northwest	800-426-2430
King Co. EOC	206-296-3830
Medical Examiner	206-731-3232
King Co. Sheriff	206-296-3311
WA State DEM	800-258-5990
South Puget Region	253-588-5217
King Co. EMS	206-296-4693

MCI Appendix 4.0

MCI Debriefing Form (Sample)

Name: _____ Date: _____

Incident:

Date: _____

Time: _____

Nature: _____

of Patients: _____

Red: _____ Yellow: _____ Green: _____ Black: _____

Location: _____

Weather: _____

Light Conditions: _____

Your area of responsibility at this MCI: _____

Was dispatch effective? _____

How many talk groups were utilized? _____

Was triage utilized? _____

Did it work well? _____

If not, why? _____

How could it be improved? _____

What method of patient numbering was utilized? _____

Did it work well? _____

If not, why? _____

How could it be improved? _____

How were the patients removed from the Treatment Areas? _____

Did it work well? _____

If not, why? _____

How could it be improved? _____

How were the Treatment Areas designated and set _____
Did it work well? _____
If not, why? _____
How could it be improved? _____

How were patients identified and removed from the Treatment Areas?

Did it work well? _____
If not, why? _____
How could it be improved? _____

Were there sufficient type and quantity of supplies? _____
If not, what was lacking? _____
How could stocking and distribution be improved? _____

How was the hospital destination determined? _____
Who provided "Medical Control" _____
Did it work well? _____
If not, why? _____
How could it be improved? _____

Did the Transport Point work well? _____
If not, why? _____
How could it be improved? _____

Were communications sufficient and effective? _____
If not, why? _____
How could it be improved? _____

Was manpower sufficient? _____
If not, why? _____
How could it be improved? _____

Your overall impression of this MCI evolution? _____

What could have been done to make this MCI more manageable? _____

All other comments are welcome regarding weather, lightning, supplies, resources, command, communications, etc. Your comments are requested solely for the purpose of helping us improve our collective response to MCI's and to better prepare for the future. Please use this reverse of separate sheets of paper.

MCI Appendix 5.0

Checklist: MCI Incident Commander

Responsibility:

To manage all operations and activities related to a specific incident.

Communications:

“Command” on the operations and dispatch talk groups.

CHECKLIST:

(Review the entire list of duties and responsibilities when possible.)

Obtain incident briefing from previous Incident Commander:

Don “Command” vest

Identify and prioritize immediate and potential objectives:

- Safety concerns
- Confirmed number of patients
- Fires
- Hazardous materials
- Extrication problems

Communicate short radio report

- Identify location
- Describe scene and nature of incident/mechanism
- Number of patients
 - Request MCI response if appropriate
- Name and location of command
- Designated parking or base
- Designate staging
- Request tactical talk groups
- Provide directions to responding units

Implement MCI Plan and appoint medical/tactical objectives

- “Operations”
 - “Triage”
 - “Medical Group Supervisor”
 - “Treatment” and “Transport”
 - “Ambulance Staging”
 - “Morgue”

Transmit all requests for additional resources

Document and relay all tactical reports

Establish Passport Accountability as necessary

Consider Unified Command:

- Law enforcement
- Public works
- Local government
- Emergency Operations Centers

Appoint and brief PIO and media liaison

Coordinate all incident records and logs

Demobilize when practical

Consider Critical Incident Stress Management

MCI Appendix 6.0

Checklist: Triage

Responsibility:

To manage all Triage activities within the Medical Group.

Communications:

“Triage” within the Medical Group Talk Group

CHECKLIST:

(Review the entire list of duties and responsibilities when possible)

Don identification vest.

Check in with supervisor and obtain briefing. Obtain initial patient count!

Request additional resources for Triage responsibilities.

Assure prompt implementation of Triage:

Designate Triage teams as necessary

Triage personnel and working quickly and accurately

(No treatment provided!)

Assure that Triage status is marked with color flagging tape

Confirm patient count

Report presence of Red patient(s)

Request additional equipment:

Triage belts Backboards Lights

Advise Command or Medical Group as patient count or Triage colors change.

Begin numbering patients:

[Establish Funnel Point if needed

Appoint Funnel Point Officer as needed]

Ensure all patients are numbered prominently.

Ensure patient numbers are recorded

Apply treatment Tags when possible

Obtain and brief litter-bearers.

Initiate patient “harvesting” based on Triage priority (RED first)

Ensure that all patients are “harvested” according to Triage priorities

[Ensure that Black patients are not moved]

Advise “Medical Group” when “harvesting” begins and approximate number of each Triage category.

Keep “Medical Group” informed of your status, patient count and additional requirements.

Direct re-Triage whenever possible

Coordinate the accurate keeping of Triage records and logs.

Downgrade Triage Team to litter-bearers of return to Staging for reassignment

Continue to direct Triage and litter-bearers until all patients except the Black have been moved through the Funnel Point.

Report to “Medical Group” for reassignment when Triage is complete.

MCI Appendix 6.1

Field Triage Outline

1. Mechanism of Injury

Assess the mechanism for “energy transfer” and injury potential.

[If hazardous-materials incident, patients must be decontaminated before being triaged, treated and transported. White triage tape indicates their “decontaminated” status.]

2. Separate the Green patients: “Everyone who can walk move over there!”

Move green patients out of danger. Keep available for help if needed. Evaluate quickly and consider transporting in bus.

3. Assess level of consciousness:

Comatose (unconscious, unresponsive)

Open the airway:

Breathes – Red

Resp. Arrest – Black [Consider resources! If appropriate, attempt to resuscitate]

Normal level of consciousness, move to next assessment.

4. Assess Breathing effort:

Can patient talk? Breathing rapidly? Gasping, grunting, stridor? Ashen or cyanotic color? Splinting and using auxiliary muscles? Struggling to breathe?

Signs of Distress – Red

Normal breathing... move on...

5. Assess Circulation:

Are signs of SHOCK present? Absent radial pulse? Decreased level of consciousness? Pale, cool, moist skin?

SHOCK – Red

Normal circulation - Yellow

MCI Appendix 7.0**Triage/Funnel Point Tracking Form (Sample)**

NUMBER	COLOR	NUMBER	COLOR	NUMBER	COLOR
1		36		71	
2		37		72	
3		38		73	
4		39		74	
5		40		75	
6		41		76	
7		42		77	
8		43		78	
9		44		79	
10		45		80	
11		46		81	
12		47		82	
13		48		83	
14		49		84	
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16		51		86	
17		52		87	
18		53		88	
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21		56		91	
22		57		92	
23		58		93	
24		59		94	
25		60		95	
26		61		96	
27		62		97	
28		63		98	
29		64		99	
30		65		100	
31		66		101	
32		67		102	
33		68		103	
34		69		104	
35		70		105	

MCI Appendix 8.0

Checklist: Medical Group Supervisor

Responsibility:

To direct and coordinate all medical activities within a specific incident, with priority given to the treatment and transport of the most critical patients.

Communications:

“Medical” or “Medical Group” within the “Operations” talk group.

CHECKLIST:

(Review the entire list of duties and responsibilities when possible)

Don “Medical Group” vest.

Report to and retrieve briefing from IC or Operations commander.

Request “Medical” talk group for medical communications.

Appoint and direct medical staff as needed:

Triage team

Patient numbering/Funnel Point

Treatment team

Red

Yellow

Green

Black (Morgue)

Transportation team

Communications with “Hospital Control”

Communications aides, runners, scribes

Provide liaison and communication “link” between medical teams and command:

Relay situational reports, including Triage numbers and patients transported and as numbers change

Anticipate and obtain necessary equipment, medical supplies and transportation vehicles.

Evaluate needs for additional resources:

ALS & BLS Personnel

Medical Examiner

Transportation vehicles

Logistical supplies: food, water

Buses

Law enforcement

Helicopter

Haz-Mat

MCI/Medical Supply Units

Ensure that adequate personnel have been assigned for all activities within the Medical Group

Consider support and/or relief for medical personnel during extended operations

Coordinate the keeping of accurate medical records.

Demobilize Medical Group as time and activity permits.

Consider need for Critical Incident Stress Management.

Appendix 9.0

“Good Samaritan” Tracking Form

DATE _____ TIME _____ INCIDENT NO. _____
 INCIDENT LOC. _____
 EMS CONTACT _____
 PH. _____ PGR _____
 PT. NAME _____ AGE _____ SEX _____
 TRANSPORT TO _____
 G. SAM NAME _____
 ADDRESS _____
 HOME PH (____) _____ WORK(____) _____
 E-MAIL _____
 LANGUAGE _____ CARD _____ OF _____



GOOD SAMARITAN FOLLOW-UP CARD

Thank you for assisting our emergency medical service personnel in the care of an injured or ill person. The willingness of King County citizens to provide aid in an emergency can make a real difference in the patient's outcome.

Sometimes assisting with patient care results in direct contact with blood and body fluids. Contact with blood or body fluids can occur through broken skin, cuts, scrapes, open sores, puncture wounds – or through the eyes, nose or mouth. **Not all exposures are significant**, yet exposure to blood or body fluids containing infectious agents can affect your health.

If you have had direct contact with blood or body fluids, please **contact Public Health – Seattle & King County at (206) 296-4774 within 24 hours**. Say that you are a Good Samaritan seeking an assessment of exposures to blood or body fluids. After business hours or weekends you will be asked to leave a message. Public Health staff will promptly return your call.

MCI Appendix 10.0

Checklist: Treatment

Responsibility:

To direct and coordinate the expeditious treatment of patients with an emphasis on preparation for transportation to regional hospitals.

Communications:

“Treatment” within the Medical Group talk group

CHECKLIST:

(Review the entire list of duties and responsibilities when possible.)

Report to and obtain briefing from IC or Medical Group Supervisor.

Number of patients within each Triage category

Determine need for, and location of, Treatment Areas:

Are they necessary? Vs. direct loading into transport vehicles

Will environmental conditions support exterior Treatment?

Do patients require shelter and warmth?

What location will best serve Transport operation?

Coordinate with transport officer to permit greatest ease of patient loading and patient accountability.

Appoint and direct Red and Yellow Treatment leaders.

Expedite treatment and transport of Red patients

Ensure that Treatment Tags are used to document vital patient information

Anticipate and request additional personnel and resources for all Treatment activities.

Ensure that Green patients have been moved, evaluated and transported

Update Medical Group Supervisor of needs and operational progress.

Coordinate treatment records and summary of activities.

Demobilize Treatment team when conditions permit.

MCI Appendix 11.0

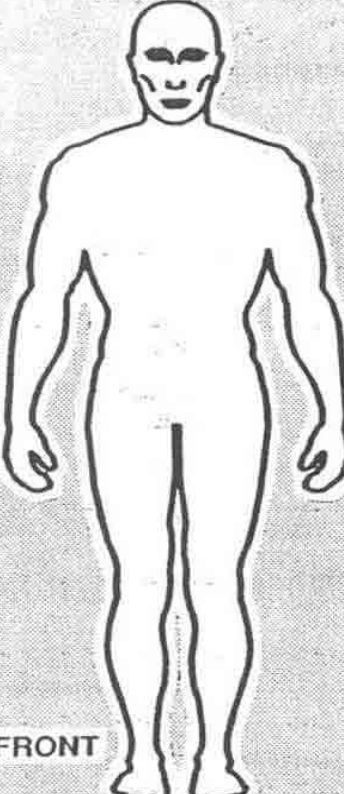
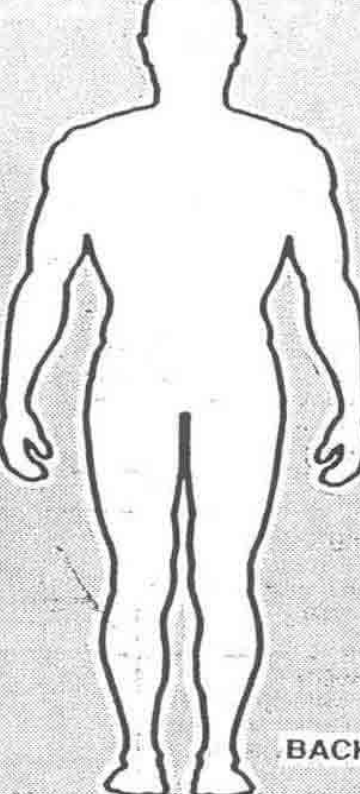
Treatment Tag (Front)

TREATMENT TAG																													
COLOR RED		PATIENT NUMBER 7																											
PRIMARY INJURY <input checked="" type="checkbox"/> HEAD <input type="checkbox"/> CHEST		<input type="checkbox"/> ABDOMEN <input type="checkbox"/> EXTREMITY <input type="checkbox"/> OTHER																											
PATIENT NAME				AGE																									
TIME																													
PULSE																													
BLOOD PRESSURE																													
RESPIRATION																													
GLASGOW																													
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 33%;">EYE OPENING</th> <th style="width: 33%;">VERBAL RESPONSE</th> <th style="width: 24%;">MOTOR RESPONSE TO PAIN</th> </tr> </thead> <tbody> <tr> <td rowspan="4" style="text-align: center; vertical-align: middle; font-weight: bold;">G L A S G O W</td> <td>1 <input type="checkbox"/> None</td> <td>1 <input type="checkbox"/> None</td> <td>1 <input type="checkbox"/> None</td> </tr> <tr> <td>2 <input type="checkbox"/> To Pain</td> <td>2 <input type="checkbox"/> Incomprehensible</td> <td>2 <input type="checkbox"/> Extension</td> </tr> <tr> <td>3 <input type="checkbox"/> To Voice</td> <td>3 <input type="checkbox"/> Inappropriate</td> <td>3 <input type="checkbox"/> Flexion</td> </tr> <tr> <td>4 <input type="checkbox"/> Spontaneous</td> <td>4 <input type="checkbox"/> Confused</td> <td>4 <input type="checkbox"/> Withdraw</td> </tr> <tr> <td></td> <td></td> <td>5 <input type="checkbox"/> Oriented</td> <td>5 <input type="checkbox"/> Purposeful Movement</td> </tr> <tr> <td></td> <td></td> <td></td> <td>6 <input type="checkbox"/> Obeys Command</td> </tr> </tbody> </table>						EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE TO PAIN	G L A S G O W	1 <input type="checkbox"/> None	1 <input type="checkbox"/> None	1 <input type="checkbox"/> None	2 <input type="checkbox"/> To Pain	2 <input type="checkbox"/> Incomprehensible	2 <input type="checkbox"/> Extension	3 <input type="checkbox"/> To Voice	3 <input type="checkbox"/> Inappropriate	3 <input type="checkbox"/> Flexion	4 <input type="checkbox"/> Spontaneous	4 <input type="checkbox"/> Confused	4 <input type="checkbox"/> Withdraw			5 <input type="checkbox"/> Oriented	5 <input type="checkbox"/> Purposeful Movement				6 <input type="checkbox"/> Obeys Command
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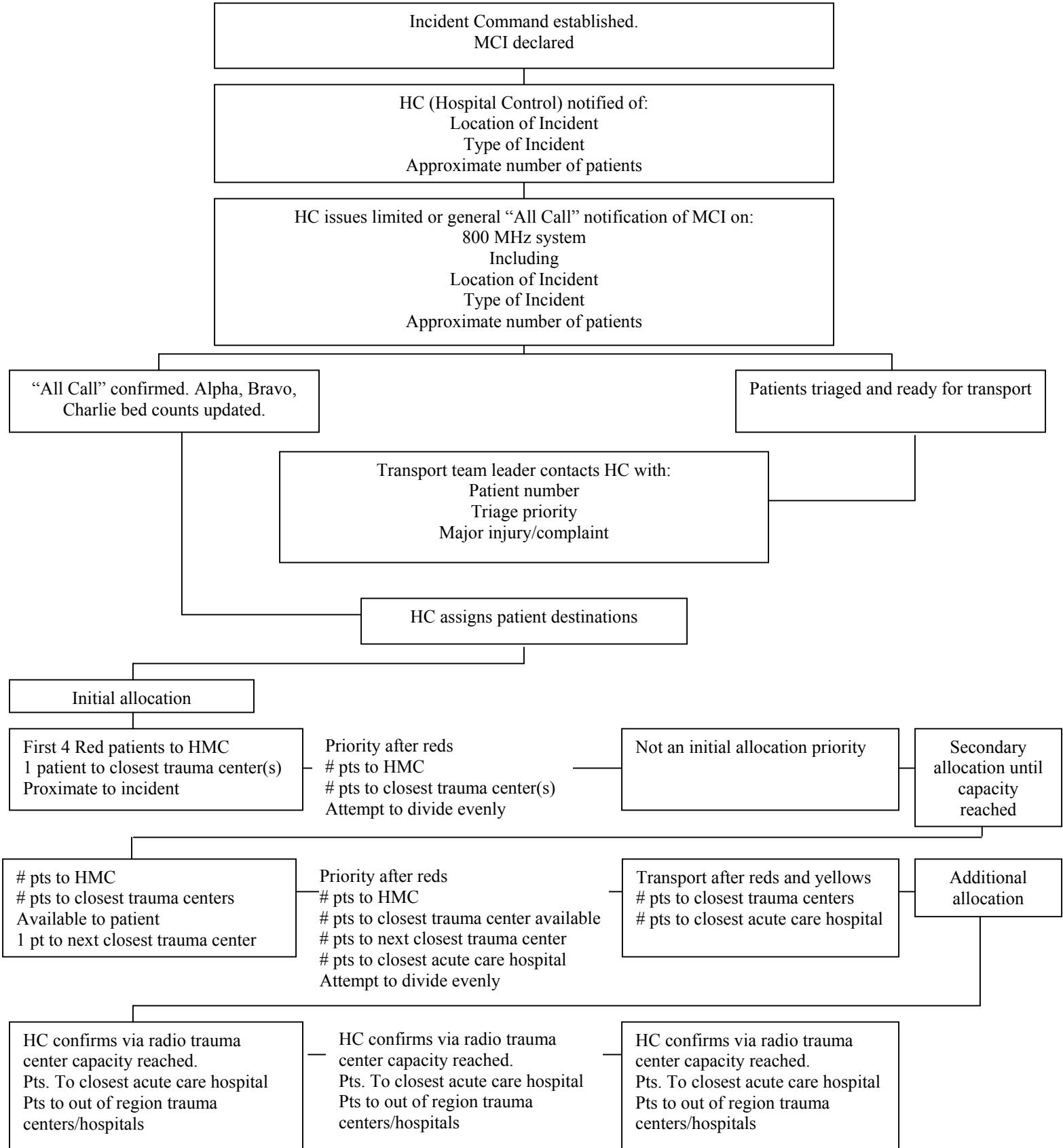
MCI Appendix 11.0

Treatment Tag (Back)

 <p>FRONT</p>	 <p>BACK</p>														
<table border="1"><tr><td>Primary Injury</td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr><tr><td>Treatment</td><td></td></tr><tr><td></td><td></td></tr><tr><td></td><td></td></tr></table>		Primary Injury								Treatment					
Primary Injury															
Treatment															
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MCI Appendix 12.0

Hospital Control (Outline)



MCI Appendix 13.0

Checklist: Transport

Responsibility:

To direct all activities related to the transportation of patients from a specific incident.

Communications:

“Transport” within the Medical Group talk group

CHECKLIST:

(Review the entire list of duties and responsibilities when possible.)

Report to the Medical Group Supervisor and obtain briefing.

Total number of patients in each Triage category

Don “Transport” vest

Coordinate with the Treatment officer the best location of the Transport area and the feasibility of direct-loading patients into transport vehicles:

Ensure that patients receive proper destinations and their data obtained before departure of transport vehicles

Anticipate and request through the Medical Group the necessary transport vehicles.

Coordinate parking to expedite transportation operations

Establish “Ambulance Staging” if necessary

Consider separate talk group for “Ambulance Staging”

Request through Medical Group the personnel and equipment necessary for patient loading and transportation activities.

Ensure that litter-bearer crews are sufficient to operate with greatest safety.

Activate “Hospital Control” to coordinate distribution of patients to regional hospitals:

Primary – Harborview

Secondary – Overlake

Continue to coordinate with treatment officer to ensure greatest efficiency in loading and transporting patients:

Keep Medical Group informed of resource needs and operational progress

Prioritize loading the transport of Red patients first, whenever possible

Coordinate keeping records and logs related to patients transported:

Treatment Tags

Status boards

Demobilize Transport personnel when possible.

Coordinate final Transport records with those of Treatment, Triage and the Medical Group.

MCI Appendix 14.0

Checklist: Morgue

Responsibility:

To provide security for and identification of dead bodies at an incident and to provide liaison with the Medical Examiner personnel.

Communications:

“Morgue” within the Medical Group talk group

CHECKLIST:

(Review the entire list of duties and responsibilities when possible.)

Report to Medical Group Supervisor and obtain briefing

Number and location of Black patients.

Medical Examiner staff present or ETA.

Don “Morgue” vest

Anticipate personnel and resources needed and request from Medical Group

Number, tag and cover bodies

Provide security of personnel effects and keep with bodies.

Do not move bodies, nor allow them to be moved, unless necessary.

Coordinate keeping of Morgue records and log.

Demobilize Morgue team when possible.

Coordinate final count of Black patients into total patient count.